

		FOR OFFICE USE					

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**2000**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2000)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH Facility ID Number:</b> <u>0036012</u></p> <p><b>Facility Name:</b> <u>Breese Nursing Home</u></p> <p><b>Address:</b> <u>1155 North First Street</u> <u>Breese</u> <u>62230</u>          Number City Zip Code</p> <p><b>County:</b> <u>Clinton</u></p> <p><b>Telephone Number:</b> <u>( 618 ) 526-4521</u> <b>Fax #</b> <u>( 618 ) 526-2833</u></p> <p><b>IDPA ID Number:</b> <u>37-1259462001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>03/09/1990</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>J. Terry Dooling</u> <b>Telephone Number:</b> <u>( 618 ) 465-7717</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2000</u> to <u>12/31/2000</u> and certify to the best of my knowledge and belief that the said content are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment</p> <table border="1"> <tr> <td rowspan="2"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Mark E. Halloran</u></td> </tr> <tr> <td rowspan="4"><b>Paid Preparer</b></td> <td>(Title) <u>President</u></td> </tr> <tr> <td>(Signed) <u>Accountants' Compilation Report Attached</u> (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>J. Terry Dooling, Partner</u></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>C.J. Schlosser &amp; Company, L.L.C.</u>  <u>233 E. Center Drive, Alton, Illinois 62002</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>( 618 ) 465-7717</u> <b>Fax #</b> <u>( 618 ) 465-7710</u></td> </tr> <tr> <td colspan="2"> <b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>          201 S. Grand Avenue East          Springfield, IL 62763-0001 <b>Phone # (217) 782-1630</b> </td> </tr> </table>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Date) _____	(Type or Print Name) <u>Mark E. Halloran</u>	<b>Paid Preparer</b>	(Title) <u>President</u>	(Signed) <u>Accountants' Compilation Report Attached</u> (Date) _____	(Print Name and Title) <u>J. Terry Dooling, Partner</u>	(Firm Name & Address) <u>C.J. Schlosser &amp; Company, L.L.C.</u> <u>233 E. Center Drive, Alton, Illinois 62002</u>		(Telephone) <u>( 618 ) 465-7717</u> <b>Fax #</b> <u>( 618 ) 465-7710</u>	<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> 201 S. Grand Avenue East Springfield, IL 62763-0001 <b>Phone # (217) 782-1630</b>	
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SEE ACCOUNTANTS' COMPILATION REPORT

DPA 3745 (N-4-99)

IL478-2471

**Print Preview**

Facility Name &amp; ID Number Breese Nursing Home

# 0036012 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	40	Skilled (SNF)	40	14,640	1
2		Skilled Pediatric (SNF/PED)			2
3	72	Intermediate (ICF)	72	26,352	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	112	TOTALS	112	40,992	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	1,669	2,572	1,392	5,633	8
9	SNF/PED					9
10	ICF	16,307	10,940		27,247	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,976	13,512	1,392	32,880	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.21%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?  
Date started 03/06/1990

J. Was the facility purchased or leased after January 1, 1978?  
YES ☒ Date 03/06/1990 NO ☐

K. Was the facility certified for Medicare during the reporting year?  
YES ☒ NO ☐ If YES, enter number of beds certified 22 and days of care provided 1392

Medicare Intermediary AdminaStar Federal

## IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2000 Fiscal Year: 12/31/2000  
\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2000 Ending: 12/31/2000  
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	167,223	594	5,253	173,070		173,070	0	173,070		1
2	Food Purchase		132,358		132,358		132,358	(1,304)	131,054		2
3	Housekeeping	71,748	16,494		88,242		88,242	0	88,242		3
4	Laundry	61,294	8,454		69,748		69,748	0	69,748		4
5	Heat and Other Utilities			81,856	81,856		81,856	0	81,856		5
6	Maintenance	36,184	12,548	25,525	74,257		74,257	0	74,257		6
7	Other (specify):* Sanitation			6,190	6,190		6,190	0	6,190		7
8	<b>TOTAL General Services</b>	336,449	170,448	118,824	625,721		625,721	(1,304)	624,417		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,800	4,800		4,800	0	4,800		9
10	Nursing and Medical Records	958,730	59,558	102,168	1,120,456	150	1,120,606	0	1,120,606		10
10a	Therapy	55,616		71,863	127,479		127,479	0	127,479		10a
11	Activities	41,675	4,130	1,200	47,005		47,005	0	47,005		11
12	Social Services	46,957		1,200	48,157		48,157	0	48,157		12
13	Nurse Aide Training			2,151	2,151		2,151	0	2,151		13
14	Program Transportation							0			14
15	Other (specify):*							0			15
16	<b>TOTAL Health Care and Programs</b>	1,102,978	63,688	183,382	1,350,048	150	1,350,198		1,350,198		16
	<b>C. General Administration</b>										
17	Administrative	144,723			144,723		144,723	0	144,723		17
18	Directors Fees							0			18
19	Professional Services			43,520	43,520		43,520	(16,398)	27,122		19
20	Dues, Fees, Subscriptions & Promotions			22,985	22,985	442	23,427	(17,197)	6,230		20
21	Clerical & General Office Expenses	113,551	40,314	31,973	185,838		185,838	(9,928)	175,910		21
22	Employee Benefits & Payroll Taxes			195,395	195,395		195,395	(3,803)	191,592		22
23	Inservice Training & Education			90	90	75	165	0	165		23
24	Travel and Seminar			4,046	4,046	(667)	3,379	(300)	3,079		24
25	Other Admin. Staff Transportation		4,865	205	5,070		5,070	0	5,070		25
26	Insurance-Prop.Liab.Malpractice			47,694	47,694		47,694	0	47,694		26
27	Other (specify):*							0			27
28	<b>TOTAL General Administration</b>	258,274	45,179	345,908	649,361	(150)	649,211	(47,626)	601,585		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,697,701	279,315	648,114	2,625,130		2,625,130	(48,930)	2,576,200		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification

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IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			99,573	99,573		99,573	28,370	127,943			30
31	Amortization of Pre-Op. & Org.			11,712	11,712		11,712	0	11,712			31
32	Interest			195,174	195,174		195,174	(15,089)	180,085			32
33	Real Estate Taxes			22,959	22,959		22,959	0	22,959			33
34	Rent-Facility & Grounds			17,340	17,340		17,340	0	17,340			34
35	Rent-Equipment & Vehicles			2,107	2,107		2,107	0	2,107			35
36	Other (specify):*							0				36
37	TOTAL Ownership			348,865	348,865		348,865	13,281	362,146			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		43,587	7,047	50,634		50,634	0	50,634			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			61,955	61,955		61,955	0	61,955			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		43,587	69,002	112,589		112,589		112,589			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,697,701	322,902	1,065,981	3,086,584	0	3,086,584	(35,649)	3,050,935			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

SEE ACCOUNTANTS' COMPILATION REPORT

**FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.**

Facility Name & ID Number Breese Nursing Home # 0036012 STATE OF ILLINOIS Report Period Beginning: 01/01/2000 Page 5  
Ending: 12/31/2000  
VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,074)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	28,370	30		9
10	Interest and Other Investment Income	(15,089)	32		10
11	Discounts, Allowances, Rebates & Refunds	(230)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,608)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(7,020)	21		18
19	Entertainment	(5,970)	20		19
20	Contributions	(300)	21		20
21	Owner or Key-Man Insurance	(3,803)	22		21
22	Special Legal Fees & Legal Retainers	(16,398)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(11,327)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(200)	Var		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (35,649)		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (35,649)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

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**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.  
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Facility Name & ID Number Breese Nursing Home

# 0036012 Report Period Beginning:

01/01/2000

Ending:

Summary A

12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary	Operating Expenses												SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I		
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,304)	0	0	0	0	0	0	0	0	0	0	(1,304)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,304)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,304)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(16,398)	0	0	0	0	0	0	0	0	0	0	(16,398)	19
20	Fees, Subscriptions & Promotions	(17,197)	0	0	0	0	0	0	0	0	0	0	(17,197)	20
21	Clerical & General Office Expenses	(9,928)	0	0	0	0	0	0	0	0	0	0	(9,928)	21
22	Employee Benefits & Payroll Taxes	(3,803)	0	0	0	0	0	0	0	0	0	0	(3,803)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(300)	0	0	0	0	0	0	0	0	0	0	(300)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(47,626)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(47,626)</b>	<b>28</b>
	<b>TOTAL Operating Expense</b>													
29	<b>(sum of lines 8,16 &amp; 28)</b>	<b>(48,930)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(48,930)</b>	<b>29</b>

**DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.**

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.  
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Breese Nursing Home

# 0036012

Report Period Beginning:

01/01/2000 Ending:

12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	28,370	0	0	0	0	0	0	0	0	0	0	28,370	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15,089)	0	0	0	0	0	0	0	0	0	0	(15,089)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>13,281</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>13,281</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(35,649)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(35,649)</b>	<b>45</b>

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE ACCOUNTANTS' COMPILATION REPORT





Facility Name &amp; ID Number

Breese Nursing Home

#

0036012

Report Period Beginning: 01/01/2000

Ending:

12/31/2000

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark E. Halloran	President		50.00%	None	38	95.00	Salary	\$ 47,066	17,1	1
2	Garrett C. Reuter		Counsel	50.00%	None	10	20.00	Salary	\$ 47,066	17,1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 94,132		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Previe

Facility Name &amp; ID Number Breese Nursing Home

# 0036012 Report Period Beginning: 01/01/2000

Ending: 2/31/2000

## VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8

Show Pgs 8E thru 8

Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number

Fax Number

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name &amp; ID Number

Breese Nursing Home

# 0036012

Report Period Beginning:

01/01/2000

Ending:

12/31/2000

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	7		8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	First Bank of O'fallon		X	Mortgage	\$15,505.82	09/06/1999	\$ 1,701,051	\$ 0	12/06/1999	8.25%	\$ 23,073	1
2	Gershman Investment Corp		X	Refinance Mortgage	\$17,832.17	03/16/2000	2,478,900	2,469,209	03/16/2035	8.125%	159,240	2
3	Union Planters Bank		X	Second Mortgage	\$3,335.36	04/06/1998	373,843	0	04/16/01	8.50%	5,562	3
4												4
5												5
	Working Capital											
6	Union Planters Bank		X	Working Capital	\$4,194.68	04/06/1998	480,000	0	04/06/2001	8.50%	7,299	6
7												7
8												8
9	TOTAL Facility Related				\$40,868.03		\$ 5,033,794	\$ 2,469,209			\$ 195,174	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 5,033,794	\$ 2,469,209			\$ 195,174	15

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name &amp; ID Number Breese Nursing Home

# 0036012

Report Period Beginning:

01/01/2000

Ending:

12/31/2000

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

## B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	\$	24,447	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	23,703	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(744)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	23,703	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	22,959	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	25,096	8
	1996	26,087	9
	1997	27,944	10
	1998	28,703	11
	1999	23,703	12

<b>FOR OHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

The payment on line 2 was for the 1999 tax year.

The accrual used on line 4 was based on the 1999 tax paid.

## NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 30,286 B. General Construction Type: Exterior Masonry Frame Reinforced Concrete Number of Stories \_\_\_\_\_

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO  
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: \_\_\_\_\_

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>174,242</u>	<u>1990</u>	<u>\$ 15,400</u>	1
2					2
3	<b>TOTALS</b>	<u>174,242</u>		<u>\$ 15,400</u>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE  
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12

Show Pgs 12C and 12

Hide Pgs 12A thru 12

STATE OF ILLINOIS

Page 12

Facility Name & ID Number Breese Nursing Home

# 0036012

Report Period Beginning:

01/01/2000 Ending: 12/31/2000

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	112		1990	1975	\$ 1,750,695	\$ 55,578	31.5	\$ 55,578		\$ 599,771	4
5											5
6											6
7											7
8											8
9	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Beg Balance			1975	10,000	317	31.5	317		3,425	9
10	Roof			1990	101,563	3,224	31.5	3,224		33,480	10
11	Air Conditioner			1990	2,828	90	31.5	90		947	11
12	Interior Renovation			1990	1,803	41	7-31.5	41		923	12
13	Air Conditioner Pad			1990	2,645	156	15	176	20	1,895	13
14	Roof			1991	48,265	1,532	31.5	1,532		14,875	14
15	Handrails			1991	4,884	155	31.5	155		1,479	15
16	Soffits & Siding			1991	11,204	356	31.5	356		3,448	16
17	Carpet			1991	1,987		7			1,987	17
18	Air Conditioner			1991	4,755	151	31.5	151		1,428	18
19	HVAC - Dining Room			1991	5,510	175	31.5	175		1,443	19
20	Cubicle Tracking			1992	1,815		7			1,815	20
21	Plastering			1992	1,952	62	31.5	62		480	21
22	Cubicle Tracking			1993	657		20	33	33	255	22
23	Carpet & Tile			1993	1,481		5			1,481	23
24	Air Conditioning			1993	5,877	151	10	588	437	4,310	24
25	Fire Alarm			1993	10,700	274	15	714	440	5,171	25
26	Front Door			1994	1,368	35	10	137	102	844	26
27	Electrical Wiring			1994	9,131	234	20	457	223	2,968	27
28	Back Patio			1994	5,137	303	10	514	211	3,425	28
29	Landscaping			1994	1,221	72	10	122	50	804	29
30	Front Parking Lot			1994	80,603	4,760	10	8,060	3,300	50,377	30
31	Lighting & Ceiling			1994	2,110	188	10	212	24	1,317	31
32	Gutters & Shutters			1994	2,111	54	27	78	24	488	32
33	Dining Room Improvements			1994	2,558	66	27	95	29	576	33
34	Plumbing			1994	4,528	116	20	226	110	1,547	34
35	Ceiling Tile			1994	614	16	12	51	35	324	35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
					\$ #VALUE!	\$ 68,106		\$ 73,144	\$ 5,038	\$ 741,283	36

\*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE  
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

# 0036012

Report Period Beginning:

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Page 12A

12/31/2000

Facility Name & ID Number Breese Nursing Home

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment.** (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Laundry Improvements		1994		1,162	30	27	43	13	294	9
10	Administrative Office Improvements		1994		1,048	27	15	70	43	472	10
11	Water Softener		1994		3,661	94	12	305	211	2,085	11
12	Air Conditioners		1994		31,460	807	10	3,148	2,341	20,191	12
13	Window Blinds		1995		6,010		20	301	301	1,528	13
14	Land Improvements		1995		1,224	76	10	122	46	632	14
15	Sign		1995		2,455		12	205	205	1,177	15
16	Parking Lot Lighting		1995		7,456		15	497	497	2,858	16
17	Flag Pole		1995		1,511	94	20	76	(18)	429	17
18	Landscaping		1995		2,206	138	10	221	83	1,214	18
19	Landscaping		1996		2,927		10	293	293	1,317	19
20	Kitchen Renovations		1996		13,339		25	534	534	2,402	20
21	Window Screens		1996		914		5	183	183	822	21
22	Remodel Nurse Station		1996		1,077		25	43	43	194	22
23	Reception Room Addition		1996		3,721		25	149	149	670	23
24	Doors - Alzheimer Unit		1996		1,030		25	41	41	186	24
25	Shrubs		1997		1,001	77	15	67	(10)	234	25
26	Fence		1997		1,141	88	15	76	(12)	292	26
27	Fixtures		1997		2,835	354	10	283	(71)	1,015	27
28	Windows		2000		35,000	411	10	3,500	3,089	3,500	28
29	Light Fixtures		2000		1,500	18	10	150	132	150	29
30	Sink Fixtures		2000		7,350	86	20	368	282	368	30
31	10 Ton HVAC		2000		10,000	118	17	588	470	588	31
32	Water Softener		2000		40,000	470	12	3,333	2,863	3,333	32
33	Water Heater		2000		1,500	17	15	100	83	100	33
34	Air Handling Unit		2000		3,000	35	15	200	165	200	34
35	Rear Parking Lot		2000		44,000	2,200	15	2,933	733	2,933	35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
					\$ #VALUE!	\$ 5,140		\$ 17,829	\$ 12,689	\$ 49,184	36

\*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview



IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE  
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

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Page 12B

Facility Name & ID Number Breese Nursing Home

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Dumpster Pad			2000	900	45	15	60	15	60	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$ 45		\$ 60	\$ 15	\$ 60	36

\*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name &amp; ID Number Breese Nursing Home

# 0036012

Report Period Beginning:

01/01/2000

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12/31/2000

## XI. OWNERSHIP COSTS (continued)

## C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 255,988	\$ 21,879	\$ 33,682	\$ 11,803	5-15 Yrs	\$ 134,393	37
38	Current Year Purchases	15,935	2,866	2,866		5-7 Yrs	2,866	38
39	Fully Depreciated Assets	370,416					370,416	39
40								40
41	TOTALS	\$ 642,339	\$ 24,745	\$ 36,548	\$ 11,803		\$ 507,675	41

## D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Facility Business	Van 1991	1991	\$ 21,781	\$	\$	\$	5	\$ 21,781	42
43	Facility Business	Wheelchair Lift	1996	4,345	501	362	(139)	12	1,810	43
44										44
45										45
46	TOTALS			\$ 26,126	\$ 501	\$ 362	\$ (139)		\$ 23,591	46

## E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 98,537	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 127,943	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 29,406	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,321,793	51

## F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Section Not Applicable	\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

## G. Construction-in-Progress

	Description	Cost	
58	Section Not Applicable	\$	58
59			59
60			60
61		\$	61

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

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## XII. RENTAL COSTS

## A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

## B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ N/A YES ☐ N/A NO16. Rental Amount for movable equipment: \$ 2,107Description: Dishwasher - \$1,800; Buffer - \$307

(Attach a schedule detailing the breakdown of movable equipment)

## C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Section Not Applicable</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current  
rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$ \_\_\_\_\_13. /2002 \$ \_\_\_\_\_14. /2003 \$ \_\_\_\_\_\* If there is an option to buy the building,  
please provide complete details on attached  
schedule.\*\* This amount plus any amortization of lease  
expense must agree with page 4, line 34.

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Facility Name & ID Number Breese Nursing Home # 0036012 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

**XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☒ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM ☐

IN OTHER FACILITY ☒

COMMUNITY COLLEGE ☐

HOURS PER AIDE 40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM ☐

IN OTHER FACILITY ☒

HOURS PER AIDE 80

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments	1,385	1,108		2,493
8	Nurse Aide Competency Tests				
9	TOTALS	\$ 1,385	\$ 1,108	\$	\$ 2,493
10	SUM OF line 9, col. 1 and 2 (e)	\$ 2,493			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ None

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	<u>4</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	<u>5</u>
2. From other facilities (f)	
TOTAL TRAINED	<u>9</u>

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
 SEE ACCOUNTANTS' COMPILATION REPORT

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XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

1		2		3		4		5		6		7		8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost									
1	Licensed Occupational Therapist	10a,3	hrs	\$	1,233	\$ 21,437	\$	1,233	\$ 21,437	1					
2	Licensed Speech and Language Development Therapist	10a,3	hrs		50	1,425		50	1,425	2					
3	Licensed Recreational Therapist		hrs							3					
4	Licensed Physical Therapist	10a,3	hrs		1,972	49,001		1,972	49,001	4					
5	Physician Care		visits							5					
6	Dental Care		visits							6					
7	Work Related Program		hrs							7					
8	Habilitation		hrs							8					
9	Pharmacy	39,2	# of prescripts				43,587		43,587	9					
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10					
11	Academic Education		hrs							11					
12	Exceptional Care Program									12					
13	Ambulance Other (specify): X-Ray	39,3 39,3					340 6,706		6,706	13					
14	TOTAL			\$	3,255	\$ 71,863	\$ 50,633	3,255	\$ 122,156	14					

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 599,143	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	271,598		3
4	Supply Inventory (priced at )	65,817		4
5	Short-Term Investments			5
6	Prepaid Insurance	17,500		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 954,058	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,400		13
14	Buildings, at Historical Cost	2,294,982		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	665,553		16
17	Accumulated Depreciation (book methods)	(1,377,022)		17
18	Deferred Charges	111,294		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,710,207	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,664,265	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 80,431	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	101,253		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,359		31
32	Accrued Real Estate Taxes(Sch.IX-B)	23,703		32
33	Accrued Interest Payable	16,719		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 231,465	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,469,209		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,469,209	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,700,674	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (36,409)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,664,265	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

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		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,456	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,456	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	82,135	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(122,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (39,865)	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (36,409)	24 *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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## STATE OF ILLINOIS

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Facility Name &amp; ID Number Breese Nursing Home

# 0036012

Report Period Beginning: 01/01/2000

Ending: 12/31/2000

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1		2	
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 3,132,044	1
2	Discounts and Allowances for all Levels	(127,522)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,004,522	3
	<b>B. Ancillary Revenue</b>		
4	Day Care	0	4
5	Other Care for Outpatients		5
6	Therapy	109,844	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 109,844	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	0	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,715	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 11,715	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	15,089	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 15,089	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Miscellaneous	27,549	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 27,549	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,168,719	30

1		2	
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	\$ 625,721	31
32	Health Care	1,350,048	32
33	General Administration	649,361	33
	<b>B. Capital Expense</b>		
34	Ownership	348,865	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	50,634	35
36	Provider Participation Fee	61,955	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,086,584	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	82,135	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 82,135	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,888	2,020	\$ 40,459	\$ 20.03	1
2	Assistant Director of Nursing	1,826	1,980	33,504	16.92	2
3	Registered Nurses	14,948	15,658	241,407	15.42	3
4	Licensed Practical Nurses	16,240	17,145	228,623	13.33	4
5	Nurse Aides & Orderlies	44,713	46,529	396,331	8.52	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,513	5,879	55,616	9.46	8
9	Activity Director					9
10	Activity Assistants	5,417	5,571	41,675	7.48	10
11	Social Service Workers	3,886	4,221	46,957	11.12	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,406	21,729	167,223	7.70	15
16	Dishwashers					16
17	Maintenance Workers	2,395	2,639	36,184	13.71	17
18	Housekeepers	10,021	10,306	71,748	6.96	18
19	Laundry	7,964	8,376	61,294	7.32	19
20	Administrator	2,016	2,157	50,592	23.45	20
21	Assistant Administrator					21
22	Other Administrative	2,496	2,496	94,131	37.71	22
23	Office Manager					23
24	Clerical	9,254	9,902	113,551	11.47	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,957	2,094	18,406	8.79	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	150,940	158,702	\$ 1,697,701 *	\$ 10.70	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	137	\$ 5,253	1,3	35
36	Medical Director	Contract	4,800	9,3	36
37	Medical Records Consultant	12	405	10,3	37
38	Nurse Consultant	3	150	10,8	38
39	Pharmacist Consultant	Contract	1,320	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Contract	1,200	11,3	44
45	Social Service Consultant	Contract	1,200	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	152	\$ 14,328		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	23	\$ 954	10,3	50
51	Licensed Practical Nurses	8	326	10,3	51
52	Nurse Aides	5,660	99,163	10,3	52
53	TOTAL (lines 50 - 52)	5,691	\$ 100,443		53

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## XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Section Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 120
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5-7 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 61,955  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? None
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,074
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. ~~Does the facility transport residents to and from day training?~~ No  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

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